

CERTIFICATE OF DEATH

Reg. Dist. No.

04406

4416

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 27 Westminster	
c. LENGTH OF STAY IN 1b 10 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wimert Avenue		d. STREET ADDRESS Wimert Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ros Middle May Last Aldridge		4. DATE OF DEATH Month April Day 24 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1886
9. AGE (In years, age (in years) (month) (day) yrs. 71		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Spencer		14. MOTHER'S MAIDEN NAME Eora Effie Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs. Blanche Logue R. 6 Westminster, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma Cerebral. 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adeno Carcinoma Rt Breast DUE TO (c) 1 yr.		INTERVAL BETWEEN ONSET AND DEATH 1 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic Heart Disease & pin Injec.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/6/57 to 4/24/58 , that I last saw the deceased alive on 4/24/58 , and that death occurred at 4:15 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE G. Allen Moulton M.D.		148 W. Main St. Westminster, Md.	
PHYSICIAN'S NAME (Type) G. Allen Moulton, M.D.		148 W. Main St. Westminster, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-27-58	22c. NAME OF CEMETERY OR CREMATORY Deer Park	22d. LOCATION (City, town, or county) (State) Smallwood, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers		ADDRESS Westminster, Maryland	
24a. REC'D BY REGISTRAR APR 28 '58		24b. REGISTRAR'S SIGNATURE Deerwood	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John A. Jones"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "1910"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
PLACE OF DEATH [Faint text, possibly "Home"]		DATE OF DEATH [Faint text, possibly "April 28, 1958"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		SIGNATURE OF PHYSICIAN [Faint signature]	
SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF NEXT OF KIN [Faint signature]	
SIGNATURE OF CLERK [Faint signature]		SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF NEXT OF KIN [Faint signature]		SIGNATURE OF DECEASED [Faint signature]	

BUREAU V. 1

APR 28 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4421

CERTIFICATE OF DEATH

04407

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>		c. LENGTH OF STAY IN 1b <u>12 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Westminster (Mayberry)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>/</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lee</u> Middle <u>H.</u> Last <u>Anderson</u>			4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>19 58</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 2, 1883</u>		9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miller-Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Timothy Anderson</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Jane Hash</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Ruth L. Anderson, Westminster, Md. R #1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary Anemia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>4/1</u> , 19 <u>52</u> to <u>4/28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/28</u> , 19 <u>58</u> , and that death occurred at <u>4:30</u> M., from the causes and on the date stated above. A. ADDRESS (Street, city or town, state) DATE SIGNED <u>Taneytown, Md. 4/28/58</u>							
ACTUAL SIGNATURE <u>R. D. McVaugh</u>		M.D. <u>Taneytown, Md.</u>					
PHYSICIAN'S NAME (Type) <u>R. S. McVaugh</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 30, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>United Bretheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Taneytown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u>				ADDRESS <u>Taneytown, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 1 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
Jan 15, 1925		Home		Heart Disease	
Time of Death		Occupation		Manner of Death	
10:30 AM		Teacher		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date of Report		Place of Report		Signature of Reporting Officer	
Jan 16, 1925		Baltimore		[Signature]	

RECORDED
INDEXED
JAN 16 1925
BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4422

CERTIFICATE OF DEATH

Reg. Dist. No.

04408

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Union Mills Rural, Nr. Westminster			c. LENGTH OF STAY IN 1b 6 Weeks		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Meadow View Convalescent Home			d. STREET ADDRESS Westminster, Md. R.D.1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) William Augustus Bowman			4. DATE OF DEATH Month 4/27/58 Day 19 Year 19		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/4/1865	9. AGE (In years last birthday) 92 yrs.	IF UNDER 1 YEAR Months 4 Days 27 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming (Retired)		11. BIRTHPLACE (State or foreign country) Carroll Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Bowman			
14. MOTHER'S MAIDEN NAME Caroline Willet		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. None		17. INFORMANT Luther A. Bowman Address Luther A. Bowman, Hanover, Pa. R. D. 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage from Small Intestine 578X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Myocarditis					INTERVAL BETWEEN ONSET AND DEATH 7 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. 11 Month 19 Day 19 Year 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 1-6 , 19 58 , to 4-27 , 19 58 , that I last saw the deceased alive on 4-27 , 19 58 , and that death occurred at 1:45P M, from the causes and on the date stated above.					
ACTUAL SIGNATURE L. L. Potter		M.D. 12 W. King, Littlestown, Pa.		ADDRESS (Street, city or town, state) LITTLESTOWN, PA	
DATE SIGNED 4-28-58		PHYSICIAN'S NAME (Type) L. L. POTTER M.D.			
22b. DATE THEREOF 4/29/58		22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		22d. LOCATION (City, town, or county) (State) Silver Run, Carroll Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little		ADDRESS Littlestown, Pa.		24a. REC'D BY REGISTRAR DATE APR 29 '58	
24b. REGISTRAR'S SIGNATURE W. Leach					

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 65		4. DATE OF BIRTH JAN 15 1893	
5. PLACE OF BIRTH BALTIMORE, MD		6. OCCUPATION Carpenter	
7. MARITAL STATUS Married		8. DATE OF MARRIAGE JUN 15 1915	
9. NAME OF SPOUSE MARY HARRIS		10. DATE OF DEATH APR 15 1958	
11. PLACE OF DEATH Home		12. CAUSE OF DEATH Heart Disease	
13. MEDICAL HISTORY Hypertension, Atherosclerosis		14. PRESENT ILLNESS Myocardial Infarction	
15. PHYSICIAN'S SIGNATURE J. H. Smith, M.D.		16. PLACE OF INTERMENT Catholic Cemetery	
17. SIGNATURE OF NEXT OF KIN John H. Harris		18. SIGNATURE OF DECEASED (If living)	
19. SIGNATURE OF WITNESSES J. H. Harris, M.D.		20. SIGNATURE OF REGISTRAR J. H. Harris	

BUREAU X. 2

APR 29 1958

RECEIVED

4423

CERTIFICATE OF DEATH

04409

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Unknown	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN TB 18ys-10mths-7dys. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		d. STREET ADDRESS 201 South East Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frederick Middle J. Last Brandau		4. DATE OF DEATH Month 4 Day 12 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-14-1885
9. AGE (In years last birthday) 72		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edward F. Brandau	
14. MOTHER'S MAIDEN NAME Hannah Steuber		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with convulsive disorder, confused state, Epilepsy, C.B.S. due to associated with convulsions.			INTERVAL BETWEEN ONSET AND DEATH days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from 4-11- 19 58 , to 4-12- 19 58 , that I last saw the deceased alive on 4-12- 19 58 , and that death occurred at 7:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital. DATE SIGNED 4-13-58			
ACTUAL SIGNATURE Agustin del Campo		PHYSICIAN'S NAME (Type) Agustin del Campo. M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 15, 1958	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC.		24a. REC'D BY REGISTRAR DATE APR 15 '58	
ADDRESS Baltimore Md.		24b. REGISTRAR'S SIGNATURE W. J. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

044110

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

15

I

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 2yrs. 2mos. 18days. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 5 S. Curley St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ellen Middle Florence Last BRANEN		4. DATE OF DEATH Month April Day 24 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 14, 1873 84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Thomas Myrick		14. MOTHER'S MAIDEN NAME Mary Roth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Address Springfield State Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Comminuted fracture, neck of right femur DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction.			INTERVAL BETWEEN ONSET AND DEATH 6 days 7 weeks
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Patient fell and broke her hip.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 3/4/58 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	20f. (City or town) Sykesville (County) Carroll (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James T. Marsh		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James T. Marsh, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4/24/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/28/58	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) Baltimore, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John A. Moran -3000 E. Baltimore St.		24a. REC'D BY REGISTRAR APR 25 '58 24b. REGISTRAR'S SIGNATURE [Signature]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 25 1958

RECEIVED

4425

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

BUREAU V. 3

8361 11 Ed. 7

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04412

4420 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD Maryland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>117 S. MAIN St</u>				STREET ADDRESS (If rural give location) <u>117 S MAIN St</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Edgar</u> (Middle) <u>Murray</u> (Last) <u>Bush</u>				(Month) <u>April</u> (Day) <u>3</u> (Year) <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec 21 1870</u>	9. AGE last birthday <u>87</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Medical</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John M. Bush</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Murray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Dr Joseph E. Bush HAMPSTEAD MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. _____		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 3</u> , 19 <u>58</u> , to <u>April 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 3</u> , 19 <u>58</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Joseph E. Bush</u>		M.D. <u>HAMPSTEAD MD</u>		ADDRESS (Street, city, town, state) <u>HAMPSTEAD MD</u>		DATE SIGNED <u>4/3/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr 6/58</u>		NAME OF CEMETERY OR CREMATORY <u>Hampstead</u>		LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>W. Search</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. E. Epton</u>		ADDRESS <u>Hampstead Md</u>	
DATE <u>APR 7 '58</u>				DATE <u>APR 7 '58</u>			

CERTIFICATE OF DEATH

1959

1959

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

4427

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. LENGTH OF STAY IN 1b 109 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				d. STREET ADDRESS 1528 N. Stricker Street			
3. NAME OF DECEASED (Type or print) First Andrew Middle Samuel Last Carey				4. DATE OF DEATH April 11 1958 Month April Day 11 Year 1958			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-7-1894	9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Snow Hill, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Carey				14. MOTHER'S MAIDEN NAME Clara ??			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. I 217-14-3755		17. INFORMANT Address Emma Carey - 1528 N. Stricker Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced pulmonary TB of military type; 002x DUE TO Potts disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from December 23, 1957 , to April 11, 1958 , that I last saw the deceased alive on April 11, 1958 , and that death occurred at 7:45 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edgars M. Maculans, M.D.			ADDRESS (Street, city or town, state) Henryton, Maryland		DATE SIGNED April 11-1958		
PHYSICIAN'S NAME (Type) Edgars M. Maculans, M. D.			HENRYTON STATE HOSPITAL				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-15-1958	22c. NAME OF CEMETERY OR CREMATORY Balto nat		22d. LOCATION (City, town, or county) (State) Balto Md			
23. FUNERAL DIRECTOR'S SIGNATURE Geo. W. Nelson			ADDRESS 1348 N. Calhoun St		24a. REC'D BY REGISTRAR DATE APR 14 '58	24b. REGISTRAR'S SIGNATURE W. H. Nelson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 14 1953

RECEIVED

4428

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville c. LENGTH OF STAY IN 1b 2 yrs. 14 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY --- c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City d. STREET ADDRESS 2927 Sylvan Avenue e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Ashby Last CLOUD		4. DATE OF DEATH Month April Day 6 Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 13, 1892
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months --- Days ---	11. IF UNDER 24 HRS. Hours --- Min. ---
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Roofing Co.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME James A. Cloud		14. MOTHER'S MAIDEN NAME Virginia W. Campbell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) 1st WW - 1919		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records of Springfield State Hospital		Address Sykesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease; coronary arterio- DUE TO sclerosis. (c) years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Chronic brain syndrome assoc. with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --- 491 X	
20c. TIME OF INJURY Month, Day, Year Hour o. m. --- p. m. --- 19 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) --- (County) --- (State) ---	
21. I certify that I attended the deceased from March 23, 1956 to April 6 , 19 58 , that I last saw the deceased alive on April 6, 1958 , and that death occurred at 8:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4/7/58			
ACTUAL SIGNATURE Martin Gross M.D. Springfield State Hospital		PHYSICIAN'S NAME (Type) Martin Gross, M. D. Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-9-58	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight ADDRESS 6009 Harford Rd.		24a. REC'D BY REGISTRAR --- 24b. REGISTRAR'S SIGNATURE ---	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF INTERMENT		PLACE OF INTERMENT		CITY	
APR 4 1968		BALTIMORE		BALTIMORE		MD.		U.S.A.		APR 10 1968		GREENWOOD CEMETERY		BALTIMORE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
APR 11 1968		APR 11 1968		APR 11 1968		APR 11 1968		APR 11 1968		APR 11 1968		APR 11 1968		APR 11 1968	

BUREAU V. S.

APR 11 1968

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

04415

4429

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Sykesville				c. LENGTH OF STAY IN life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARJORIE Middle ANTHA Last Collins				4. DATE OF DEATH Month April Day 12 Year 1958			
5. SEX female		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-10-1902	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 55 Days 12 Hours 12 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Levi Rheubottom				14. MOTHER'S MAIDEN NAME Alvina V. Dorsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Norman R. Collins, Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE Coronary Thrombosis, 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension, Obesity DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH DEC 14 57 to APR 11 58	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from DEC 14 57 , to APR 11 58 , that I last saw the deceased alive on 12 April 1958 , and that death occurred at 6:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Howard E. Hall M.D.				ADDRESS (Street, city or town, state) Sykesville, Md DATE SIGNED 12 April 58			
PHYSICIAN'S NAME (Type) HOWARD E. HALL							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-15-1958		22c. NAME OF CEMETERY Johnsville		22d. LOCATION (City, town, or county) (State) Carroll Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,				ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR DATE APR 11 1958	
				24b. REGISTRAR'S SIGNATURE			

APR 15 1959

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4430

Reg. Dist. No.

FOR STATE
HEALTH DEPT

M

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY ---		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 25 yrs, 10 mo	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3V01-4		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			d. STREET ADDRESS NORWOOD RD, 4403 1999		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First EDWARD Middle J. Last COSTIN			4. DATE OF DEATH Month April Day 13 Year 1958		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-5-01		9. AGE (In years last birthday) 56 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Typist		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME General B. Costin		
14. MOTHER'S MAIDEN NAME Nora E. Davis			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. ---			17. INFORMANT records of Springfield State Hospital		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) schizophrenic reaction, unspecified					INTERVAL BETWEEN ONSET AND DEATH "mu"
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. --- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	
20f. (City or town) ---		(County) ---		(State) ---	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James T. Marsh			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) JAMES T. MARSH			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			22b. DATE THEREOF 4/16/58		22c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK
22d. LOCATION (City, town, or county) WOODLAWN		(State) MD.		24a. REC'D BY REGISTRAR APR 21 '58	
23. FUNERAL DIRECTOR'S SIGNATURE WITZKE FUNERAL, 4101 EDMONDSON AVE			24b. REGISTRAR'S SIGNATURE W. T. Marsh		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

APR 21 1958

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4417 CERTIFICATE OF DEATH

04417

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>H Westminster</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rustertown</i> 03X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>127 E Green St.</i>		d. STREET ADDRESS <i>222 Main St</i>	
3. NAME OF DECEASED (Type or print) First <i>Charlotte</i> Middle <i>H</i> Last <i>Cullison</i>		4. DATE OF DEATH Month <i>April</i> Day <i>27</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 11 1878</i> 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>md.</i>	
11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Lewis D. Gore</i>		14. MOTHER'S MAIDEN NAME <i>Martha Frazier</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mrs. Inez C. Haine</i>		Address <i>H Westminster md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>442X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio Sclerotic Cardio Revol</i> (c) <i>arterio-sclerotic Hypertension & myocardial degeneration</i>			INTERVAL BETWEEN ONSET AND DEATH <i>12 da</i> <i>1450</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>962X Cerebral Hemorrhage 1955 - 1958</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>Fell at Home</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <i>June 30 1956</i> Hour a. m. <i>2:00</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Her Home</i>		20f. (City or town) (County) (State) <i>Rustertown Paets md</i>	
21. I certify that I attended the deceased from <i>Dec 1955</i> 1955, to <i>April 27</i> 1958, that I last saw the deceased alive on <i>Dec 26</i> 1958, and that death occurred at <i>7:50 PM</i> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W. L. Specker</i>		ADDRESS (Street, city or town, state) <i>Westminster md</i>	
PHYSICIAN'S NAME (Type) <i>W. L. Specker</i>		DATE SIGNED <i>4/28/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>April 30/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Round Ridge</i>		22d. LOCATION (City, town, or county) (State) <i>Pikesville md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. F. Elmer & Sons</i>		ADDRESS <i>Rustertown, md</i>	
24a. REC'D BY REGISTRAR <i>APR 30 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. L. Specker</i>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>	
<p>4. DATE OF DEATH <i>April 10, 1938</i></p>		<p>5. TIME OF DEATH <i>10:00 AM</i></p>		<p>6. PLACE OF DEATH <i>Home</i></p>	
<p>7. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>8. MANNER OF DEATH <i>Natural</i></p>		<p>9. PLACE OF BIRTH <i>Baltimore, Md.</i></p>	
<p>10. OCCUPATION <i>Teacher</i></p>		<p>11. MARITAL STATUS <i>Married</i></p>		<p>12. EDUCATION <i>High School</i></p>	
<p>13. PREVIOUS ILLNESS <i>None</i></p>		<p>14. MEDICAL HISTORY <i>None</i></p>		<p>15. SIGNATURE OF DECEASED <i>John Doe</i></p>	
<p>16. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>17. SIGNATURE OF PHYSICIAN <i>John Doe</i></p>		<p>18. SIGNATURE OF REGISTRAR <i>John Doe</i></p>	

BUREAU Y. L.

APR 30 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4431

CERTIFICATE OF DEATH

04418

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 1556.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 729 Silver Spring Avenue			
3. NAME OF DECEASED (Type or print) First Lawson Middle Brown Last CULP				4. DATE OF DEATH Month April Day 17 Year 19 58			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 23, 1879	
				9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. telegraph operator				10b. KIND OF BUSINESS OR INDUSTRY (If retired) Clerk - DC Gov't. (Retired)			
13. FATHER'S NAME John Green Culp				14. MOTHER'S MAIDEN NAME Margaret Cobb			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. NONE			
				17. INFORMANT Address Sykesville, Md. Records of Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Not DUE TO Branchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH Days Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) —				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. — 19				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	
20f. (City or town) —				20g. (County) —			
20h. (State) —				20i. (State) —			
21. I certify that I attended the deceased from September 17, 1957 , to April 17, 1958 , that I last saw the deceased alive on April 17, 1958 , and that death occurred at 4:30AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Agustin del Campo				ADDRESS (Street, city or town, state) Springfield State Hospital			
PHYSICIAN'S NAME (Type) Agustin del Campo				DATE SIGNED 4/17/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 4/19/58		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY	
22d. LOCATION (City, town, or county) PRINCE GEORGE COUNTY, MARYLAND				22e. (State) MARYLAND			
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE Apr 18 '58	
24b. REGISTRAR'S SIGNATURE W. E. Leach							

BUREAU V. S.

APR 18 1958

RECEIVED

4432

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN TB 3yrs. 11mos. 14days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 1000 Middlesex Rd.			
3. NAME OF DECEASED (Type or print) First Theresa Marie Atkinson Middle DANEKER Last DANEKER				4. DATE OF DEATH Month April Day 10 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 03 Days 54 Hours 2		IF UNDER 24 HRS. Hours 2 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME George Atkinson				14. MOTHER'S MAIDEN NAME Elizabeth Atkinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic heart disease. INTERVAL BETWEEN ONSET AND DEATH Years DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X (b) Generalized arteriosclerosis. Years (c) Diabetes Mellitus and gangrene of right foot.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with dist. of metab., growth or nutrition, with senile brain disease with psychotic reaction.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 7, 19 55 , to April 10, 19 58 that I last saw the deceased alive on April 9, 19 58 , and that death occurred at 6:00A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Agustin del Campo				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 4/10/58	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-12-58		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook-Blight, 6009 Harford Road				24a. REC'D BY REGISTRAR DATE APR 21 '58		24b. REGISTRAR'S SIGNATURE Archer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 22 1953

RECEIVED

4433

CERTIFICATE OF DEATH

Reg. Dist. No.

04420

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 2 months 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 0353-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS unknown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alvin Middle Dean Last Davis				4. DATE OF DEATH Month 4 Day 5 Year 1958			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-8-82		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY General Labor		11. BIRTHPLACE (State or foreign country) unkn		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unkn (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unkn		17. INFORMANT S.S. Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) Bronchopneumonia XXXX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.S. assoc. with senile brain disease with psych. reaction						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-8- 19 58 to 4-5- 19 58 , that I last saw the deceased alive on 4-4- 19 58 , and that death occurred at 8:15A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4-5-58							
ACTUAL SIGNATURE Edmund Lusthaus				M.D. Springfield State Hospital			
PHYSICIAN'S NAME (Type) Edmund Lusthaus				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-8-58		22c. NAME OF CEMETERY OR CREMATORY Donville		22d. LOCATION (City, town, or county) (State) Donville, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Haight				ADDRESS Chapinville, Md.		24a. REC'D BY REGISTRAR DATE 4-10-58	
				24b. REGISTRAR'S SIGNATURE W. H. H.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. DATE OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF CORONER		13. SIGNATURE OF WITNESSES		14. SIGNATURE OF DECEASED		15. SIGNATURE OF FUNERAL HOME	
16. SIGNATURE OF COUNTY CLERK		17. SIGNATURE OF STATE CLERK		18. SIGNATURE OF DEPARTMENT CLERK		19. SIGNATURE OF DEPARTMENT CLERK		20. SIGNATURE OF DEPARTMENT CLERK	

RECEIVED
APR 11 1958
BUREAU V. 2

4434

CERTIFICATE OF DEATH

04421

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY * Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 21yrs.9mos.11days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS -	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elsie Middle Bell Last DODD		4. DATE OF DEATH Month April Day 24, Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1898
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 59 Days 59 Hours 59 Min. 59	IF UNDER 24 HRS. Months 59 Days 59 Hours 59 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Dodd		14. MOTHER'S MAIDEN NAME Louise Bell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Chronic rheumatic heart disease DUE TO (c) Mental Deficiency with epilepsy. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 1955 , to April 24, 1958 , that I last saw the deceased alive on April 24, 1958 , and that death occurred at 3:25P M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustin del Campo M.D.		ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 4/24/58	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 28, 1958	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Colgate, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.		24a. REC'D BY REGISTRAR DATE APR 28 '58	
24b. REGISTRAR'S SIGNATURE Alfred			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		Jan 1, 1900	
Place of Birth		Race		Occupation		Cause of Death	
Baltimore, Md		White		Teacher		Heart Disease	
Date of Death		Time of Death		Place of Death		Physician	
Apr 15, 1958		10:30 AM		Home		Dr. J. Smith	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

APR 29 1958

RECEIVED

4435 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Balto. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 5yrs. 1mo. 8days c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 0352.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 3 Winters Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Walter Rudolph DOY LE		4. DATE OF DEATH Month Day Year April 15, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 15, 1894 9. AGE (In years last birthday) 63 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY CONTRACTING	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LAWRENCE R. DOYLE		14. MOTHER'S MAIDEN NAME Sarah R. Doyle (CRUMWINE)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH Minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Involuntary psychotic reaction, Pulmonary tuberculosis, far advanced, active. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 002-X		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from September 27, 1955 , to April 15, 1958 , that I last saw the deceased alive on 4/14/58 , and that death occurred at 7:30A M, from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Julian Radcykowycz M.D. Springfield State Hospital 4/15/58 PHYSICIAN'S NAME (Type) Julian Radcykowycz Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4-18-58	
22c. NAME OF CEMETERY OR CREMATORY Meadow Branch		22d. LOCATION (City, town, or county) _____ (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Forley Funeral Home - Catonsville, Md.		24a. REC'D BY REGISTRAR DATE APR 17 '58	
24b. REGISTRAR'S SIGNATURE Reed			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1936 41 Ed.

RECEIVED

4436

CERTIFICATE OF DEATH

04423

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>Grant</u> Middle <u>Duwall</u> Last			4. DATE OF DEATH <u>April</u> Month <u>15</u> Day <u>19</u> Year <u>58</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 15, 1898</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Constructor</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>		
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>William G. Duwall</u>			14. MOTHER'S MAIDEN NAME <u>Burgenetta Holmes</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>213-16-0630</u>		
17. INFORMANT <u>Christine Duwall - Sykesville, Md.</u>			Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>LEFT HEART FAILURE</u> DUE TO (c) <u>H. C. V. D.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>24 hrs.</u> <u>3 yrs.</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. <u>19</u> p. m.	Month <u>DEC</u>	Day <u>31</u>	Year <u>1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <u>Sykesville, Md.</u>		(County)		(State)	

21. I certify that I attended the deceased from <u>DEC 31, 1957</u> to <u>APR 15, 1958</u> , that I last saw the deceased alive on <u>APR 15, 1958</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>R. V. Houck, Jr.</u>	DATE SIGNED <u>4-16-58</u>
PHYSICIAN'S NAME (Type) <u>R. V. HOUCK, JR.</u>	ADDRESS (Street, city or town, state) <u>SYKESVILLE, MD.</u>

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-18-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Freedom</u>	22d. LOCATION (City, town, or county) <u>Sykesville, Carroll Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u>		ADDRESS <u>Sykesville, Md.</u>	24a. REC'D BY REGISTRAR <u>APR 21 '58</u>
		24b. REGISTRAR'S SIGNATURE <u>W. L. Lewis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 21 1958

BUREAU V. S.

RECEIVED

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4437

CERTIFICATE OF DEATH

04424

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. LENGTH OF STAY IN 1b since 1952			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Henryton, Maryland			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Emilija Middle Eglitis Last Eglitis				4. DATE OF DEATH Month April Day 23 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 19, 1893	
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 64 Days 64 Hours 64 Min.		11. BIRTHPLACE (State or foreign country) Latvia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician				10b. KIND OF BUSINESS OR INDUSTRY Medicine			
13. FATHER'S NAME Peters Jansons				14. MOTHER'S MAIDEN NAME Lizeta Laucins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Dr. Rudolfs Eglitis - Henryton, Md. - Husband			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer of vulva, inoperable, recurrent. DUE TO (c) Generalized deforming Arthritis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 1957 to April 23, 1958 , that I last saw the deceased alive on April 23, 1958 , and that death occurred at 7:35 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edgars M. Maculans		ADDRESS (Street, city or town, state) Henryton, Maryland				DATE SIGNED 4-23-58	
PHYSICIAN'S NAME (Type) Edgars M. Maculans, M. D.		Henryton, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8-24-58		22c. NAME OF CEMETERY OR CREMATORY Rondon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth H. Hight				ADDRESS Seaside, Md.		24a. REC'D BY REGISTRAR APR 28 '58	
				24b. REGISTRAR'S SIGNATURE W. Search			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 28 1938

RECEIVED

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4438

CERTIFICATE OF DEATH

04425

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Henryton</u>			c. LENGTH OF STAY IN 1b <u>1,304</u> days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Henryton State Hospital</u>				d. STREET ADDRESS <u>507 Pine Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Abraham</u> Last <u>Fisher</u>		4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1958</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 12, 1890</u>	
9. AGE (In years lost birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Emanuel Fisher</u>				14. MOTHER'S MAIDEN NAME <u>Louise Charlett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-16-6542</u>		17. INFORMANT <u>Walter A. Fisher - Patient</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Far advanced pulmonary tuberculosis.</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) _____ (c) _____ DUE TO (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Sept. 7</u> , 19 <u>54</u> , to <u>April 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 3</u> , 19 <u>58</u> , and that death occurred at <u>9:30 A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edgars M. Maculans</u>				ADDRESS (Street, city or town, state) <u>Henryton, Maryland</u>		DATE SIGNED <u>4-3-58</u>	
PHYSICIAN'S NAME (Type) <u>Edgars M. Maculans, M. D.</u>				<u>Henryton State Hospital</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>				ADDRESS <u>Wintersville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 9 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Overman</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. S.

APR 9 1933

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4439

CERTIFICATE OF DEATH

Reg. Dist. No.

04426

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 26yrs.25days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 ✓	
d. STREET ADDRESS 116 W. University Parkway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle F. Last FLYNN		4. DATE OF DEATH Month April Day 20 , Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 16, 1885
9. AGE (In years last birthday) yrs. 72		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James E. Flynn		14. MOTHER'S MAIDEN NAME Anna C. Brauer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute mediastinitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cancer of the esophagus DUE TO (b) Schizophrenic reaction, other and unspecified (c) Schizophrenic reaction, other and unspecified PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH Days Months			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 1955 , to April 20, 1958 , that I last saw the deceased alive on April 20, 1958 , and that death occurred at 4:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4/21/58 ACTUAL SIGNATURE Agustin del Campo M.D. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/58	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE WM. J. TICKNER & SONS, BALTO. 17, Md. (BPB)		24a. RECEIVED BY REGISTRAR APR 22 1958 24b. REGISTRAR'S SIGNATURE W. J. Tickner	

18 MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

BUREAU V. S.

APR 24 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04427

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millers</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millers</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Curtis Le Roy Graf</u>		4. DATE OF DEATH <u>April 18</u> 19 <u>58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/24/1892</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Garment Mfg</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co Md</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John S. Graf</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Hunt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-32-4191</u>	
17. INFORMANT <u>Mrs. Corinne Graf Miller</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Cell Carcinoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> 19 <u>47</u> , to <u>April</u> 19 <u>58</u> , that I last saw the deceased alive on <u>4/17</u> 19 <u>58</u> , and that death occurred at <u>5 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Foward</u>		DATE SIGNED <u>4/17/58</u>	
PHYSICIAN'S NAME (Type) <u>W. H. Foward M.D.</u>		ADDRESS (Street, city or town, state) <u>Manchester, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4/21/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Manchester</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick Bucker Hammer</u>		24a. REGD BY REGISTRAR <u>APR 22 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Foward</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4441

CERTIFICATE OF DEATH

Reg. Dist. No. 04428

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		c. LENGTH OF STAY IN 1b <u>YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WHYTE STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Howard</u> First <u>GRAY</u> Middle <u>Gray</u> Last		4. DATE OF DEATH <u>APRIL</u> Month <u>14</u> Day <u>1958</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>M</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 31-1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ELECTRIC</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JACOB GRAY</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE MEREDITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-03-1061</u>	
17. INFORMANT <u>ELLA F GRAY</u> Address <u>UNION BRIDGE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma head of pancreas</u> 157x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>24 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept</u> 19 <u>56</u> , to <u>Apr 14</u> 19 <u>58</u> , that I last saw the deceased alive on <u>Apr 13</u> 19 <u>58</u> , and that death occurred at <u>2 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James J. Marsh</u> M.D.		ADDRESS (Street, city or town, state) <u>Washington</u> DATE SIGNED <u>4/15/58</u>	
PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>APRIL 16-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>METHODIST</u>	22d. LOCATION (City, town, or county) (State) <u>UNION TOWN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hartzler & Sons</u> ADDRESS <u>Union Bridge, Md</u>		24a. REC'D BY REGISTRAR <u>APR 17 '58</u> DATE	24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. MAR 20 1968

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

BUREAU V. S.

APR 17 1968

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RECEIVED

APR 30 1958

BUREAU V. R.

STATE
HEALTH DEPT.

RECEIVED
APR 30 1958

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2103

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4443

CERTIFICATE OF DEATH

04430

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
c. LENGTH OF STAY IN 1b 2yrs. 1mo. 7days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Address unknown. - Baltimore City.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 3V01.4	
3. NAME OF DECEASED (Type or print) First Henry Middle HAGER Last HAGER		4. DATE OF DEATH Month April Day 30, Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1881
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Hager		14. MOTHER'S MAIDEN NAME Barbara -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Generalized arteriosclerosis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction. Ischio-rectal abscess. Osteomyelitis, right leg.		INTERVAL BETWEEN ONSET AND DEATH Years Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 23, 19 56 , to April 30, 19 58 , that I last saw the deceased alive on April 29, 19 58 , and that death occurred at 1:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4/30/58			
ACTUAL SIGNATURE Agustin del Campo M.D.		PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) 56158		22b. DATE THEREOF 5/1/58	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank A. Henkel, Baltimore, Md.		24a. REC'D BY REGISTRAR DATE MAY 2 '58	
24b. REGISTRAR'S SIGNATURE Deborah			

4444

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL, WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL, WESTMINSTER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GORSUCH ROAD</u>				d. STREET ADDRESS <u>GORSUCH ROAD</u>			
3. NAME OF DECEASED (Type or print) First <u>LESTER</u> Middle <u>M.</u> Last <u>HEFLIN</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>19</u> Year <u>1958</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 4, 1891</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MT. CABINET WORKER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CABINET SHOP</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>WORLD WAR I</u>				16. SOCIAL SECURITY NO. <u>212-07-3477</u>			
17. INFORMANT <u>MRS. HILDA R. HEFLIN</u>				Address <u>GORSUCH RD. WESTMINSTER, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u> <u>2 + yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Jan 10 1958</u> to <u>Apr 19 1958</u> , that I last saw the deceased alive on <u>Feb 17 1958</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E Reese Wilkens</u>				ADDRESS (Street, city or town, state) <u>15 Kender Ave. Westminster, Md.</u>			
DATE SIGNED <u>4/21/58</u>							
PHYSICIAN'S NAME (Type) <u>E REESE WILKENS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 23/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTO. NATIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul E. Chenoweth</u>				ADDRESS <u>3615-17-19</u>		24a. REC'D BY REGISTRAR DATE <u>APR 22 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. L. Search</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>JOHN J. MURPHY</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>1892</i></p>	
<p>5. PLACE OF BIRTH <i>NEW YORK</i></p>		<p>6. OCCUPATION <i>Engineer</i></p>	
<p>7. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>8. MANNER OF DEATH <i>Natural</i></p>	
<p>9. DATE OF DEATH <i>April 10, 1939</i></p>		<p>10. TIME OF DEATH <i>10:30 AM</i></p>	
<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. SIGNATURE OF PHYSICIAN <i>John J. Murphy</i></p>	
<p>13. SIGNATURE OF REGISTRAR <i>John J. Murphy</i></p>		<p>14. SIGNATURE OF WITNESSES <i>John J. Murphy</i></p>	

BUREAU V. S.

APR 20 1939

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4445

CERTIFICATE OF DEATH

04432

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 4yrs. 5mos. 8days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 3403 Toone St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Frances Middle Agnes Last HESS				4. DATE OF DEATH Month April Day 25 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 13, 1888 69yrs.		9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hess				14. MOTHER'S MAIDEN NAME Mary Ann Fisher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, acute, interstitial 492X NEPHRITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephritis, suppurative, acute DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, catatonic type							INTERVAL BETWEEN ONSET AND DEATH Days Days
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 20, 19 54 to April 25, 19 58 , that I last saw the deceased alive on April 25, 19 58 , and that death occurred at 10:30P M, from the causes on and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4/26/58			
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-29-58		22c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.		22d. LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Zeiler				ADDRESS 901 S. Conkling		24a. REC'D BY REGISTRAR W. H. Smith	
				24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 28 1958

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. S.

APR 29 1953

RECEIVED

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4446

CERTIFICATE OF DEATH

Reg. Dist. No.

04433

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 15 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle HOLMES Last HOLMES				4. DATE OF DEATH Month April Day 20 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 8, 1879	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min. 78		IF UNDER 24 HRS. Months 78 Days 78 Hours 78 Min. 78			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ice wagon driver				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Holmes				14. MOTHER'S MAIDEN NAME Sarah Hughes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X arteriosclerotic heart disease Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.				INTERVAL BETWEEN ONSET AND DEATH Days Years Years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 5, 1958 , to April 20, 1958 , that I last saw the deceased alive on April 20, 1958 , and that death occurred at 7:20 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4/21/58 ACTUAL SIGNATURE Agustin del Campo M.D. Springfield State Hospital PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 4-24-58		22c. NAME OF CEMETERY OR CREMATORY New C thedral Cemetery	
22d. LOCATION (City, town, or county) (State) Baltimore, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE APR 25 '58		24b. REGISTRAR'S SIGNATURE W. Search	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 23 1968

BUREAU V. 2

STATE OF MARYLAND
DEPARTMENT OF HEALTH - PATRONS 12
CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF BIRTH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

4447

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville (Rural)		c. LENGTH OF STAY IN 1b 9 mo. 13 das.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 27 Westminster			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Maude Last Horton				4. DATE OF DEATH Month April Day 15 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1890		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charlie Warner Warner				14. MOTHER'S MAIDEN NAME Mary Jane			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Springfield Hospital Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.							INTERVAL BETWEEN ONSET AND DEATH days years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1957 , to April 15, 1958 , that I last saw the deceased alive on April 15, 1958 , and that death occurred at 8:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Rita S. Glahn M.D. Springfield State Hospital 4/15/58 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Rita S. Glahn, M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-17-1958		22c. NAME OF CEMETERY OR CREMATORY Ebenezer		22d. LOCATION (City, town, or county) (State) Carroll Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. M. Waltz, Winfield, Md.				24a. REC'D BY REGISTRAR DATE APR 17 '58		24b. REGISTRAR'S SIGNATURE <i>W. L. Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 17 1958

RECEIVED

Page 1 of 1

MANHATTAN STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

NAME OF DECEASED [Illegible]		SEX [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		MEDICAL HISTORY [Illegible]	
OCCUPATION [Illegible]		EDUCATION [Illegible]	
RELIGION [Illegible]		MARITAL STATUS [Illegible]	
SOCIAL SECURITY NUMBER [Illegible]		SIGNATURE OF DECEASED [Illegible]	
SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF CORONER [Illegible]		SIGNATURE OF JUDGE [Illegible]	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4418

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 WESTMINSTER</u>	
c. LENGTH OF STAY IN 1b <u>LIFE</u>		d. STREET ADDRESS <u>196 PENNSYLVANIA AVE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>WILLIAM</u> Middle <u>KAUFFMAN</u> Last		4. DATE OF DEATH <u>APR. 7</u> Month <u>7</u> Day <u>1958</u> Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR. 19-1880</u> 77 yrs.
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DROVER</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE L. KAUFFMAN</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN E. CRAWFORD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-07-9214</u>	
17. INFORMANT <u>J. W. Kauffman</u> Address <u>96 Pennsylvania Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>MIN.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James J. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/10/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>KRIDERS</u>		22d. LOCATION (City, town, or county) (State) <u>Westminster Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Z. Myers Jr Westminster Md.</u>		24a. REC'D BY REGISTRAR <u>APR 9 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Quinn</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
MARCH 20

BUREAU V. E.

APR 9 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4448

CERTIFICATE OF DEATH

Reg. Dist. No. 04436

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>27 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>R.F.D. 2 Box 115</u>			
3. NAME OF DECEASED (Type or print) First <u>Elmer</u> Middle <u>Benson</u> Last <u>KEMP</u>				4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-1-72</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John E. Kemp</u>				14. MOTHER'S MAIDEN NAME <u>Annie Belt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-24-5288</u>			
17. INFORMANT <u>Springfield State Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. associated with senile brain disease with psychosis.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March 11,</u> 19 <u>58</u> , to <u>April 8,</u> 19 <u>58</u> , that I last saw the deceased alive on <u>April 8,</u> 19 <u>58</u> , and that death occurred at <u>6:25 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>4/8/58</u>							
ACTUAL SIGNATURE <u>Agustin del Campo</u> M.D.				PHYSICIAN'S NAME (Type) <u>Agustin del Campo, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Apr 11 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Berryman</u>				ADDRESS <u>Reisterstown Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 10 58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF PHYSICIAN	
10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF BURIAL OFFICIAL		14. SIGNATURE OF FUNERAL HOME		15. SIGNATURE OF CHURCH	
16. SIGNATURE OF CEMETERY		17. SIGNATURE OF INTERVIEWER		18. SIGNATURE OF INTERVIEWEE	
19. SIGNATURE OF INTERVIEWER		20. SIGNATURE OF INTERVIEWEE		21. SIGNATURE OF INTERVIEWER	
22. SIGNATURE OF INTERVIEWEE		23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF INTERVIEWEE	
25. SIGNATURE OF INTERVIEWER		26. SIGNATURE OF INTERVIEWEE		27. SIGNATURE OF INTERVIEWER	
28. SIGNATURE OF INTERVIEWEE		29. SIGNATURE OF INTERVIEWER		30. SIGNATURE OF INTERVIEWEE	
31. SIGNATURE OF INTERVIEWER		32. SIGNATURE OF INTERVIEWEE		33. SIGNATURE OF INTERVIEWER	
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49. SIGNATURE OF INTERVIEWER		50. SIGNATURE OF INTERVIEWEE		51. SIGNATURE OF INTERVIEWER	
52. SIGNATURE OF INTERVIEWEE		53. SIGNATURE OF INTERVIEWER		54. SIGNATURE OF INTERVIEWEE	
55. SIGNATURE OF INTERVIEWER		56. SIGNATURE OF INTERVIEWEE		57. SIGNATURE OF INTERVIEWER	
58. SIGNATURE OF INTERVIEWEE		59. SIGNATURE OF INTERVIEWER		60. SIGNATURE OF INTERVIEWEE	
61. SIGNATURE OF INTERVIEWER		62. SIGNATURE OF INTERVIEWEE		63. SIGNATURE OF INTERVIEWER	
64. SIGNATURE OF INTERVIEWEE		65. SIGNATURE OF INTERVIEWER		66. SIGNATURE OF INTERVIEWEE	
67. SIGNATURE OF INTERVIEWER		68. SIGNATURE OF INTERVIEWEE		69. SIGNATURE OF INTERVIEWER	
70. SIGNATURE OF INTERVIEWEE		71. SIGNATURE OF INTERVIEWER		72. SIGNATURE OF INTERVIEWEE	
73. SIGNATURE OF INTERVIEWER		74. SIGNATURE OF INTERVIEWEE		75. SIGNATURE OF INTERVIEWER	
76. SIGNATURE OF INTERVIEWEE		77. SIGNATURE OF INTERVIEWER		78. SIGNATURE OF INTERVIEWEE	
79. SIGNATURE OF INTERVIEWER		80. SIGNATURE OF INTERVIEWEE		81. SIGNATURE OF INTERVIEWER	
82. SIGNATURE OF INTERVIEWEE		83. SIGNATURE OF INTERVIEWER		84. SIGNATURE OF INTERVIEWEE	
85. SIGNATURE OF INTERVIEWER		86. SIGNATURE OF INTERVIEWEE		87. SIGNATURE OF INTERVIEWER	
88. SIGNATURE OF INTERVIEWEE		89. SIGNATURE OF INTERVIEWER		90. SIGNATURE OF INTERVIEWEE	
91. SIGNATURE OF INTERVIEWER		92. SIGNATURE OF INTERVIEWEE		93. SIGNATURE OF INTERVIEWER	
94. SIGNATURE OF INTERVIEWEE		95. SIGNATURE OF INTERVIEWER		96. SIGNATURE OF INTERVIEWEE	
97. SIGNATURE OF INTERVIEWER		98. SIGNATURE OF INTERVIEWEE		99. SIGNATURE OF INTERVIEWER	
100. SIGNATURE OF INTERVIEWEE		101. SIGNATURE OF INTERVIEWER		102. SIGNATURE OF INTERVIEWEE	

RECEIVED
APR 10 1953
BUREAU V. S.

4449 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Mifflin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Levittown</u> 75 x 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>117 S Main St</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u> Rufus </u> Middle <u> Jackson </u> Last <u> Kemp </u>				4. DATE OF DEATH Month <u> April </u> Day <u> 21 </u> Year <u> 1958 </u>			
5. SEX <u> male </u>	6. COLOR OR RACE <u> white </u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u> Sept 27-1889 </u>	9. AGE (In years last birthday) <u> 68 </u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> Hardw.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> Woodstock College </u>		11. BIRTHPLACE (State or foreign country) <u> Maryland </u>		12. CITIZEN OF WHAT COUNTRY? <u> U.S.A. </u>	
13. FATHER'S NAME <u> Jacob Joseph Kemp </u>				14. MOTHER'S MAIDEN NAME <u> Annie Stacy Baker </u>			
15. WAS DECEASED EVER IN U. S. ARMY OR FORCES? (Yes, no, or unknown) <u> Yes </u> (If yes, give war or dates of service) <u> World War I </u>		16. SOCIAL SECURITY NO. <u> 218-10-9626 </u>		17. INFORMANT Address <u> Ella Mae Grooms, Finksburg Md </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u> Coronary Occlusion </u> <u> 420.1 </u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> 19 </u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u> April 21 </u> , 19 <u> 58 </u> , to <u> April 21 </u> , 19 <u> 58 </u> , that I last saw the deceased alive on <u> April 21 </u> , 19 <u> 58 </u> , and that death occurred at <u> 8 P. </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> Hampstead Md </u> DATE SIGNED <u> 4/21/58 </u> ACTUAL SIGNATURE <u> Joseph E. Bush </u> M.D. PHYSICIAN'S NAME (Type) <u> Joseph E. Bush, MD </u> <u> Hampstead Maryland </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> Burial </u>		22b. DATE THEREOF <u> April 24/58 </u>		22c. NAME OF CEMETERY OR CREMATORY <u> Rockville Cem. </u>		22d. LOCATION (City, town, or county) (State) <u> Montgomery Co Md </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u> Edwin E. Clifton </u> ADDRESS <u> Hampstead Md </u>				24a. REC'D BY REGISTRAR <u> APR 28 '58 </u>		24b. REGISTRAR'S SIGNATURE <u> [Signature] </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 28 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4450

CERTIFICATE OF DEATH

04438

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Springfield				c. LENGTH OF STAY IN 1b 5yrs. 11mos. 1day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret Middle Wittman Last KOHL				4. DATE OF DEATH Month April Day 24 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1867	9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Wittman				14. MOTHER'S MAIDEN NAME Catherine Hauenstein			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Springfield Hospital Records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic heart disease (c) Generalized arteriosclerosis DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) C.B.S. assoc. with dist. of metabolism, growth or nutrition, with senile brain disease without qualifying phrase.						INTERVAL BETWEEN ONSET AND DEATH Days Years Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 1955 , to April 24, 1958 , that I last saw the deceased alive on April 24, 1958 , and that death occurred at 11:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4/24/58							
ACTUAL SIGNATURE Agustini del Campo		PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-26-58		22c. NAME OF CEMETERY OR CREMATORY Landon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Haight				24a. REC'D BY REGISTRAR DATE APR 28 58		24b. REGISTRAR'S SIGNATURE W. J. Leach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

FILE NO.

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT

NAME OF OFFICIAL

NAME OF OFFICIAL

NAME OF OFFICIAL

BUREAU V. 3

APR 28 1933

RECEIVED

4451

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 3yrs. 7mos. 12days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 27 N. Carey St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Anthony Middle KUDLAUSKA Last KUDLAUSKA				4. DATE OF DEATH Month April Day 9 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown	
9. AGE (In years less birthday) yrs. 65		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Lithuania	
12. CITIZEN OF WHAT COUNTRY? Lithuania ✓							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 4444		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH Days Years Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with dist. of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 7, 1955 , to April 9, 1958 , that I last saw the deceased alive on April 9, 1958 , and that death occurred at 11:05AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Springfield State Hospital				DATE SIGNED 4/9/58			
ACTUAL SIGNATURE Agustin del Campo				M.D. Springfield State Hospital			
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		4-12-58		Springfield Hospital		Sykesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Haight				ADDRESS Sykesville, Md.		24a. REC'D BY REGISTRAR DATE APR 16 '58	
						24b. REGISTRAR'S SIGNATURE Arthur A. Haight	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
APR 4 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APR 4 1968		MEMPHIS		MEMPHIS		TENNESSEE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SIBLINGS		PARENTS	
HEART DISEASE		NATURAL		BUSINESSMAN		HIGH SCHOOL		METHODIST		MARRIED		2		2		2	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
APR 4 1968		APR 4 1968		APR 4 1968		APR 4 1968		APR 4 1968		APR 4 1968		APR 4 1968		APR 4 1968		APR 4 1968	

BUREAU V. 8

APR 16 1968

RECEIVED

4452

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland. b. COUNTY Howard County 152	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge 13x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		d. STREET ADDRESS Box 226 Elkridge 27.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Dirk Middle Last Lottman		4. DATE OF DEATH Month 4- Day 13- Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-4-1956
9. AGE (In years last birthday) 102 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Germany	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Lottman		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. Hospital records.	
17. INFORMANT Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491x not DUE TO Arteriosclerotic heart disease. Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO Generalized arteriosclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH days years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-27- 19 57 , to 4-13- 19 58 , that I last saw the deceased alive on 4-13- 19 58 , and that death occurred at 2.10P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital. 4-13-58	
ACTUAL SIGNATURE Agustin del Campo M.D.			
PHYSICIAN'S NAME (Type) Agustin del Campo M.D.			
22a. BURIAL-CREATION-REMOVAL (Specify)	22b. DATE THEREOF 4.16.58	22c. NAME OF CEMETERY OR CREMATORY W. of Md. Med. School	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE APR 18 '58	24b. REGISTRAR'S SIGNATURE W. H. Beach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

PLACE OF BIRTH Baltimore, Maryland		PLACE OF DEATH Baltimore, Maryland	
SEX Male		AGE 35	
OCCUPATION Doctor		CAUSE OF DEATH Typhoid fever	
DATE OF DEATH 1918		TIME OF DEATH 10:00 AM	
PLACE OF INTERMENT St. Mary's Cemetery		NAME OF FUNERAL HOME ...	
SIGNATURE OF DECEASED ...		SIGNATURE OF WITNESS ...	
SIGNATURE OF PHYSICIAN ...		SIGNATURE OF MINISTER ...	
SIGNATURE OF CORONER ...		SIGNATURE OF JURY ...	

RECEIVED
 BUREAU V. S.
 1918

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04441

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4453

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 y 3 m 24d	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 16, Md.		d. STREET ADDRESS 6000 Hamilton Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frederick Peter Metzger		4. DATE OF DEATH Month 4 Day 5 Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-23-18 92
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY B & O RR	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unkn Bartholmeu Metzger		14. MOTHER'S MAIDEN NAME unkn Mary W. Gray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES World War 1		16. SOCIAL SECURITY NO. unkn	
17. INFORMANT S.S. Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. brain syndr. assoc. with circulatory disturb. with cerebral arterioscl with psych. reaction		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Apparently was knocked down by another patient	
20c. TIME OF INJURY Month 2 Day 23 Year 58 Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital ward		20f. (City or town) (County) (State) Sykesville, Carroll, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James T. Marsh		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) James T. Marsh		DATE SIGNED 4-5-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-9-58	
22c. NAME OF CEMETERY OR CREMATORY US National		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		24a. REC'D BY REGISTRAR DATE APR 9 1958	
ADDRESS 4107 Wilkens Ave		24b. REGISTRAR'S SIGNATURE Arthur	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

HEALTH CERT
FOR STATE

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age	
Mary W. Gray		86	
Sex		Race	
Female		White	
Marital Status		Date of Death	
Married		April 8, 1958	
Place of Death		Cause of Death	
Home		Natural Causes	
Occupation		Signature of Examiner	
None		[Signature]	

BUREAU V. 2

APR 9 1958

RECEIVED

Howard H. Hubbard, 1107 Wilkens Ave
US National
Baltimore 4-9-58

04442

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				b. COUNTY Wicomico					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN lb 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				2212-2					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				d. STREET ADDRESS 118 Chestnut Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First James		Middle T.		Last Mitchell		4. DATE OF DEATH Month April		Day 23,		Year 1958	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) 69 7 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT				Address					

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c):]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a)	Cardiovascular insufficiency	
002X DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost.	(b)	Far advanced pulmonary Tbc. with cavitation
	DUE TO	
	(c)	Tumor of prostate
PART II. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

MEDICAL CERTIFICATE	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
	20c. TIME OF INJURY	Month	Day	Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
	Hour			19	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20f. (City or town)
						(County)
						(State)

21. I certify that I attended the deceased from April 17, 1958, to April 23, 1958, that I last saw the deceased alive on April 23, 1958, and that death occurred on 10:30P M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 4-23-58

ACTUAL SIGNATURE Edgars M. Maculans M.D. Henryton, Maryland

PHYSICIAN'S NAME (Type) Edgars M. Maculans, M.D. Henryton State Hospital, Henryton,

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)
		St. Mary's Cemetery, Frank		
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE	
Frank D. Navel	Vicksburg, Ind.	DATE APR 22 1958	R. L. Beach	

4454 CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible] DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible] OCCUPATION: [illegible]

DATE OF DEATH: [illegible] TIME OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

SIGNATURE OF DECEASED: [illegible]

SIGNATURE OF WITNESSES: [illegible]

SIGNATURE OF PHYSICIAN: [illegible]

SIGNATURE OF REGISTRAR: [illegible]

DATE OF REGISTRATION: [illegible]

PLACE OF REGISTRATION: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

BUREAU X-5

APR 28 1958

RECEIVED

State of Maryland

Department of Health

BUREAU OF TUBERCULOSIS

Henryton State Hospital



Superintendent

EDGARS M. MACULANS, M.D.

STATE BOARD OF HEALTH

MAURICE C. PINCOFFS, M.D.
RALPH J. YOUNG, M.D.
A. AUSTIN PEARRE, M.D.
LLOYD N. RICHARDSON, PHAR. D.
GEORGE M. ANDERSON, D.D.S.
A. L. PENNIMAN, JR., P.E.
HUNTINGTON WILLIAMS, M.D., DR. P.H.
PERRY F. PRATHER, M.D., CHAIRMAN

Henryton, Maryland

March 24, 1958

TO WHOM IT MAY CONCERN:

RE: James T. Mitchell

As you will note on the Death Certificate of the above mentioned,
many questions are not answered. This patient was admitted to the hospital
in a critical condition and was unable to give us any information at all.
He was transferred here from the Prince George's General Hospital.

Signed Marie E. Thomas
Marie E. Thomas

BUREAU V. F.

APR 30 1958

RECEIVED

1 8 M 15 1 0 OP VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 8 M 15 1 0 OP VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4455

CERTIFICATE OF DEATH

Reg. Dist. No. 04443

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 3mos. 23days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First David Middle Henry Last MULLEN		4. DATE OF DEATH Month April Day 24 , Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1886
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR: Months 3 Days 01 Hours 4 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steamfitter		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David H. Mullen		14. MOTHER'S MAIDEN NAME Susan Rebecca Gnamer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 216-03-8271	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) -		INTERVAL BETWEEN ONSET AND DEATH Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease, with psychotic reaction. Gangrene of toe.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1, 1958 , to April 24, 1958 , that I last saw the deceased alive on April 24, 1958 , and that death occurred at 10:58 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustin del Campo M.D.		ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 4/24/58	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		SYKESVILLE, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4-28-1958	22c. NAME OF CEMETERY OR CREMATORY ST. MARY'S (GOWANS)	22d. LOCATION (City, town, or county) (State) Baltimore Md
23. FUNERAL DIRECTOR'S SIGNATURE Glenn F. Seif		ADDRESS 5209 York Rd Baltimore Md.	
24a. REC'D BY REGISTRAR APR 25 '58		24b. REGISTRAR'S SIGNATURE W. J. Seif	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 14

CERTIFICATE OF DEATH

BUREAU V. 3

APR 28 1958

RECEIVED

4456 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>			c. LENGTH OF STAY IN 1b <u>40 years</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Belle</u> Last <u>Null</u>				4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 9, 1881</u>		9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William G. Witherow</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Amelia Staub</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Francis W. Null, 3901 N. 31st St., Arlington, Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Lung</u> 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Abdominal Carcinoma</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>1 year</u>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-19</u> , 19 <u>57</u> , to <u>4-6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4-5</u> , 19 <u>58</u> , and that death occurred at <u>12:40 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. L. Potter</u>				ADDRESS (Street, city or town, state) <u>Littlestown, Pa.</u>		DATE SIGNED <u>4-2-58</u>	
PHYSICIAN'S NAME (Type) <u>L. L. POTTER</u>				<u>LITTLESTOWN, PA.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 8, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Taneytown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u>				ADDRESS <u>Taneytown, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>APR 8 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Alfred</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

PR 0 1958

RECEIVED

4419

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER 27</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>72 1/2 BOND ST.</u>				d. STREET ADDRESS <u>72 1/2 BOND</u>			
3. NAME OF DECEASED (Type or print) <u>LAURA</u> First <u>M.</u> Middle <u>NYGREN</u> Last				4. DATE OF DEATH <u>APRIL</u> Month <u>7</u> Day <u>1958</u> Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 8, 1888</u>		9. AGE (In years last birthday) <u>70</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R.N. NURSE ENSIGN U.S. NAVY</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>GUSTAF NYGREN</u>				14. MOTHER'S MAIDEN NAME <u>MART SWARTZBAUGH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW 1+2</u>				16. SOCIAL SECURITY NO. <u>212-40-5156</u>		17. INFORMANT <u>SUSIE B. COPPERSMITH</u> Address <u>72 1/2 BOND ST. WESTMINSTER MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u> <u>6 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arthritis, probably rheumatoid</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>49</u> , to <u>April 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 6</u> , 19 <u>58</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. Reese Wilkens</u> M.D.				ADDRESS (Street, city or town, state) <u>15 Kenney ave</u> DATE SIGNED <u>4/8/58</u>			
PHYSICIAN'S NAME (Type) <u>D.E. REESE WILKENS</u>				<u>Westminster Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER CEM</u>		22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David G. Bankard</u> ADDRESS <u>Westminster Md.</u>				24a. REC'D BY REGISTRAR <u>APR 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Al. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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THE DEPT. OF HEALTH

PAGE OF THREE

MARYLAND

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DATE OF DEATH

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BUREAU V. 5

APR 14 1958

RECEIVED

STATE DEPARTMENT OF HEALTH - BALTIMORE 10

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4457

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 5yrs.7mos.21days Tracey's Landing 02x-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joshua Middle PADDY Last		4. DATE OF DEATH Month April Day 9 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1883
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 74 Days	IF UNDER 24 HRS. Hours 74 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm hand		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Paddy		14. MOTHER'S MAIDEN NAME Margaret Lyles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pulmonary tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tuberculous bronchopneumonia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. with senile brain disease with psychotic reaction in a mental defective, severe, with pulmonary tuberculosis.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 9:45A o. m. 4/3/58 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	20f. (City or town) (County) (State) Sykesville Carroll Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James T. Marsh		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James T. Marsh, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/9/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/12/58	22c. NAME OF CEMETERY OR CREMATORY Friendship	22d. LOCATION (City, town, or county) (State) Friendship Md.
23. FUNERAL DIRECTOR'S SIGNATURE T A Hardesty & Son		24a. REC'D BY REGISTRAR DATE APR 14 '58	
ADDRESS Sykesville, Md		24b. REGISTRAR'S SIGNATURE Overman	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1933

BUREAU V. 3

APR 14 1938

RECEIVED

4458

CERTIFICATE OF DEATH

Reg. Dist. No.

04447

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City 311	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville	c. LENGTH OF STAY IN 1b 4 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		d. STREET ADDRESS 2516 Fleet Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mamie Middle Smith Last Peters		4. DATE OF DEATH Month 4 Day 4 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-2-1878
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown housekeeper		10b. KIND OF BUSINESS OR INDUSTRY at Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown Jacob Smith	
14. MOTHER'S MAIDEN NAME Unknown Bertha		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. none		17. INFORMANT Address Hospital records.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with disturbance of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-26- 1958 , to 4-4- 1958 , that I last saw the deceased alive on 4-4- 1958 , and that death occurred at 2:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital. DATE SIGNED 4-4-1958			
ACTUAL SIGNATURE Agustin del Campo		M.D. Springfield State Hospital.	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/9/58	22c. NAME OF CEMETERY OR CREMATORY ST. MATTHEWS CEMETERY	22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND.
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC BALTO. MD.		24a. REC'D BY REGISTRAR APR 9 '58	24b. REGISTRAR'S SIGNATURE Dee Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF DEATH [Illegible]		5. TIME OF DEATH [Illegible]		6. PLACE OF DEATH [Illegible]	
7. CAUSE OF DEATH [Illegible]		8. MANNER OF DEATH [Illegible]		9. SIGNATURE OF PHYSICIAN [Illegible]	
10. SIGNATURE OF REGISTRAR [Illegible]		11. DATE OF REGISTRATION [Illegible]		12. OFFICE OF REGISTRAR [Illegible]	

BUREAU V. 3

APR 9 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4459

CERTIFICATE OF DEATH

04448

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eldersburg				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oklahoma Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FLENOX Middle PURKEY Last PURKEY				4. DATE OF DEATH Month April Day 27 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 17, 1885	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 72 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Tenn	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Wilson Purkey				14. MOTHER'S MAIDEN NAME Armenda Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. ?		17. INFORMANT Lemie Purkey, Sykesville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO (b) Chronic fibrillation DUE TO (c) Coronary and pulmonary thrombosis CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease							INTERVAL BETWEEN ONSET AND DEATH 3 weeks 3 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from after he expired , to 19 , that I last saw the deceased alive on April 27 , 19 58 , and that death occurred at 10:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 37 central Ave Sykesville Maryland DATE SIGNED 4-28-58 ACTUAL SIGNATURE Bertrand R Gau PHYSICIAN'S NAME (Type) Bertrand R Gau							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-1-58		22c. NAME OF CEMETERY OR CREMATORY Stanford		22d. LOCATION (City, town, or county) (State) Sneedville, Tenn.	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE APR 30 '58		24b. REGISTRAR'S SIGNATURE W. Leach	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
PLACE OF BIRTH		CITY		STATE		COUNTRY	
OCCUPATION		EDUCATION		MARRIAGE		DATE	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS		DATE	

BUREAU N. B.

APR 30 1958

RECEIVED

Bentley

4460

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville (Rural)				c. LENGTH OF STAY IN 1b 25 yr. 11 mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS Woodlawn 03X-2			
3. NAME OF DECEASED (Type or print) First Bertie Middle Feidler Last Rau				4. DATE OF DEATH Month April Day 14 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 27, 1908		9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY City Hospitals		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James E. Feidler				14. MOTHER'S MAIDEN NAME Bertie W. Sellen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Springfield Hospital Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 521X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple lung abscesses DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH Days Weeks						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reactions, other and unspecified.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1958 , to April 14, 1958 , that I last saw the deceased alive on April 13, 1958 , and that death occurred at 7 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital Sykesville, Md. DATE SIGNED _____							
ACTUAL SIGNATURE Rita S. Glahn		M.D. Springfield State Hospital Sykesville, Md.					
PHYSICIAN'S NAME (Type) Rita S. GLAHN							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 4-24-58		22c. NAME OF CEMETERY OR CREMATORY Springfield Hospital		22d. LOCATION (City, town, or county) (State) Sykesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight				ADDRESS Sykesville, Md.		24a. REC'D BY REGISTRAR DATE APR 28 '58	
				24b. REGISTRAR'S SIGNATURE Overman			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 28 1953

RECEIVED

4461 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 26 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				2. USUAL RESIDENCE (Place deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 3V01-4 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 13, d. STREET ADDRESS 1724 E. Lafayette Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles Dowell Reid				4. DATE OF DEATH Month 4 Day 24 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-19-69	
9. AGE (In years last birthday) yrs. 88		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bank teller		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 213-18-7244		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 4 days. Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with cerebral arteriosclerosis, with psychotic reaction.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 491X					
20c. TIME OF INJURY Hour a. m. Month 19 Day 19 Year p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-28- , 19 58 , to 4-24 , 19 58 , that I last saw the deceased alive on 4-24 , 19 58 , and that death occurred at 5:00 A . M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4-24-1958							
ACTUAL SIGNATURE Riva Novey m. d.				PHYSICIAN'S NAME (Type) Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) 4-28-58		22b. DATE THEREOF 4-28-58		22c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT		22d. LOCATION (City, town, or county) (State) BALTO MD	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard Luck				24a. REC'D BY REGISTRAR DATE APR 25 '58		24b. REGISTRAR'S SIGNATURE Alf. Leach	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained at the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

RECEIVED

APR 25 1959

BUREAU V. S.

4462

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2mos. 21days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Benjamin Middle Burge Last REIN		4. DATE OF DEATH Month April Day 29 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 1, 1912
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Rein		14. MOTHER'S MAIDEN NAME Mary Meyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 35-0-2135	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary carcinoma of the liver with metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychoneurotic reaction, depressive reaction.			INTERVAL BETWEEN ONSET AND DEATH Months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 8, 1958 , to April 29, 1958 , that I last saw the deceased alive on April 29, 1958 , and that death occurred at 9:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmund Lusthaus		DATE SIGNED 4/29/58	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 1-58	
22c. NAME OF CEMETERY OR CREMATORY St. Elizabeth's		22d. LOCATION (City, town, or county) (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Gertrude Lenny		ADDRESS Larville C.	
24a. REC'D BY REGISTRAR DATE 2 '58		24b. REGISTRAR'S SIGNATURE Reinhardt	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4463 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>York</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover Pa.</u> 75x-3 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lory Vico Nursing Home</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>MARSBY</u> Middle <u>J.</u> Last <u>ROTH</u>				4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 21 1866</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Religion</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Bennetville ROTH</u>				14. MOTHER'S MAIDEN NAME <u>MARY DATZEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>JAMES M. ROTH</u> Address <u>314 W. HANOVER ST HANOVER PA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>1-21</u> , 19 <u>55</u> , to <u>4-7</u> , 19 <u>58</u> that I last saw the deceased alive on <u>April 1</u> , 19 <u>58</u> , and that death occurred at <u>7:26</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.				ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>4/7/58</u>			
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush</u>				ADDRESS <u>Hampstead Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Hanover Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Elmer: Sons Rustertown Md</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>APR 9 58</u> DATE		24b. REGISTRAR'S SIGNATURE _____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. B.

APR 9 1958

RECEIVED

4464 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City 311	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3yr.10mth.23 dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		e. STREET ADDRESS 1535 Holbrook St.	
3. NAME OF DECEASED (Type or print) First Alice Middle A Last Royston		4. DATE OF DEATH Month 4 Day 27 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-16-07
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Royston Richard S. Royston		14. MOTHER'S MAIDEN NAME Nellie Crowther	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute peritonitis DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Perforated duodenal ulcer (c) Chronic rheumatic heart disease			INTERVAL BETWEEN ONSET AND DEATH Days Months Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with C.N.S. syphilis, meningoencephalitic, with psychotic reaction.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 1955 , to April 27, 1958 , that I last saw the deceased alive on April 27, 1958 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustin del Campo		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		DATE SIGNED 4/28/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 30-58	
22c. NAME OF CEMETERY OR CREMATORY Poplar Grove Methodist Cem. Warren		22d. LOCATION (City, town, or county) (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Deffel Bros		ADDRESS 7110 Belair Rd	
24a. REC'D BY REGISTRAR DATE APR 30 '58		24b. REGISTRAR'S SIGNATURE W. L. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

ILLINOIS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		35		Jan 1, 1920		Chicago, Ill.		Chicago, Ill.		Heart Disease		Jan 15, 1955		Chicago, Ill.		10:00 AM		J. Doe, M.D.		J. Doe, M.D.	
Occupation		Marital Status		Previous Illnesses		Date of Last Examination		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition	
Teacher		Married		None		Jan 1, 1955		Jan 15, 1955		Jan 15, 1955		Jan 15, 1955		Jan 15, 1955		Jan 15, 1955		Jan 15, 1955		Jan 15, 1955		Jan 15, 1955	
Date of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition		Date of Disposition		Date of Disposition		Date of Disposition	
Jan 15, 1955		Chicago, Ill.		10:00 AM		J. Doe, M.D.		J. Doe, M.D.		Jan 15, 1955		Jan 15, 1955		Jan 15, 1955		Jan 15, 1955		Jan 15, 1955		Jan 15, 1955		Jan 15, 1955	

BUREAU V. 1

APR 30 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4465 CERTIFICATE OF DEATH

04454

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Balto. County			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 1 mo. 20 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 22 0353.2			
f. STREET ADDRESS 7845 St. Claire Lane				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Emery Last RUBY				4. DATE OF DEATH Month April Day 10 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1905	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-09-1131		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis, far advanced, active 002x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with organic brain disease.						INTERVAL BETWEEN ONSET AND DEATH Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from February 20, 1958 , to April 10, 1958 , that I last saw the deceased alive on April 10, 1958 , and that death occurred at 5:10 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus			M.D. Springfield Hospital		DATE SIGNED 4/11/58		
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.			Sykesville, Maryland.				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/14/58	22c. NAME OF CEMETERY OR CREMATORY GARDENS FAITH		22d. LOCATION (City, town, or county) (State) BALTO. CO., MD			
23. FUNERAL DIRECTOR'S SIGNATURE Walter Burke Brady			ADDRESS Baltimore, Md		24a. REC'D BY REGISTRAR DATE APR 15 '58	24b. REGISTRAR'S SIGNATURE W. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]	
3. AGE [Illegible]		4. DATE OF BIRTH [Illegible]	
5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. MARITAL STATUS [Illegible]		8. CAUSE OF DEATH [Illegible]	
9. MEDICAL HISTORY [Illegible]		10. SIGNATURE OF PHYSICIAN [Illegible]	
11. SIGNATURE OF REGISTRAR [Illegible]		12. DATE OF DEATH [Illegible]	
13. PLACE OF DEATH [Illegible]		14. SIGNATURE OF WITNESS [Illegible]	
15. SIGNATURE OF DECEASED [Illegible]		16. SIGNATURE OF NEXT OF KIN [Illegible]	
17. SIGNATURE OF BURIAL OFFICIAL [Illegible]		18. SIGNATURE OF CHURCH OFFICIAL [Illegible]	
19. SIGNATURE OF MINISTER [Illegible]		20. SIGNATURE OF CLERGYMAN [Illegible]	
21. SIGNATURE OF CHURCH OFFICIAL [Illegible]		22. SIGNATURE OF MINISTER [Illegible]	
23. SIGNATURE OF CLERGYMAN [Illegible]		24. SIGNATURE OF CHURCH OFFICIAL [Illegible]	
25. SIGNATURE OF MINISTER [Illegible]		26. SIGNATURE OF CLERGYMAN [Illegible]	
27. SIGNATURE OF CHURCH OFFICIAL [Illegible]		28. SIGNATURE OF MINISTER [Illegible]	
29. SIGNATURE OF CLERGYMAN [Illegible]		30. SIGNATURE OF CHURCH OFFICIAL [Illegible]	
31. SIGNATURE OF MINISTER [Illegible]		32. SIGNATURE OF CLERGYMAN [Illegible]	
33. SIGNATURE OF CHURCH OFFICIAL [Illegible]		34. SIGNATURE OF MINISTER [Illegible]	
35. SIGNATURE OF CLERGYMAN [Illegible]		36. SIGNATURE OF CHURCH OFFICIAL [Illegible]	
37. SIGNATURE OF MINISTER [Illegible]		38. SIGNATURE OF CLERGYMAN [Illegible]	
39. SIGNATURE OF CHURCH OFFICIAL [Illegible]		40. SIGNATURE OF MINISTER [Illegible]	
41. SIGNATURE OF CLERGYMAN [Illegible]		42. SIGNATURE OF CHURCH OFFICIAL [Illegible]	
43. SIGNATURE OF MINISTER [Illegible]		44. SIGNATURE OF CLERGYMAN [Illegible]	
45. SIGNATURE OF CHURCH OFFICIAL [Illegible]		46. SIGNATURE OF MINISTER [Illegible]	
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55. SIGNATURE OF MINISTER [Illegible]		56. SIGNATURE OF CLERGYMAN [Illegible]	
57. SIGNATURE OF CHURCH OFFICIAL [Illegible]		58. SIGNATURE OF MINISTER [Illegible]	
59. SIGNATURE OF CLERGYMAN [Illegible]		60. SIGNATURE OF CHURCH OFFICIAL [Illegible]	
61. SIGNATURE OF MINISTER [Illegible]		62. SIGNATURE OF CLERGYMAN [Illegible]	
63. SIGNATURE OF CHURCH OFFICIAL [Illegible]		64. SIGNATURE OF MINISTER [Illegible]	
65. SIGNATURE OF CLERGYMAN [Illegible]		66. SIGNATURE OF CHURCH OFFICIAL [Illegible]	
67. SIGNATURE OF MINISTER [Illegible]		68. SIGNATURE OF CLERGYMAN [Illegible]	
69. SIGNATURE OF CHURCH OFFICIAL [Illegible]		70. SIGNATURE OF MINISTER [Illegible]	
71. SIGNATURE OF CLERGYMAN [Illegible]		72. SIGNATURE OF CHURCH OFFICIAL [Illegible]	
73. SIGNATURE OF MINISTER [Illegible]		74. SIGNATURE OF CLERGYMAN [Illegible]	
75. SIGNATURE OF CHURCH OFFICIAL [Illegible]		76. SIGNATURE OF MINISTER [Illegible]	
77. SIGNATURE OF CLERGYMAN [Illegible]		78. SIGNATURE OF CHURCH OFFICIAL [Illegible]	
79. SIGNATURE OF MINISTER [Illegible]		80. SIGNATURE OF CLERGYMAN [Illegible]	
81. SIGNATURE OF CHURCH OFFICIAL [Illegible]		82. SIGNATURE OF MINISTER [Illegible]	
83. SIGNATURE OF CLERGYMAN [Illegible]		84. SIGNATURE OF CHURCH OFFICIAL [Illegible]	
85. SIGNATURE OF MINISTER [Illegible]		86. SIGNATURE OF CLERGYMAN [Illegible]	
87. SIGNATURE OF CHURCH OFFICIAL [Illegible]		88. SIGNATURE OF MINISTER [Illegible]	
89. SIGNATURE OF CLERGYMAN [Illegible]		90. SIGNATURE OF CHURCH OFFICIAL [Illegible]	
91. SIGNATURE OF MINISTER [Illegible]		92. SIGNATURE OF CLERGYMAN [Illegible]	
93. SIGNATURE OF CHURCH OFFICIAL [Illegible]		94. SIGNATURE OF MINISTER [Illegible]	
95. SIGNATURE OF CLERGYMAN [Illegible]		96. SIGNATURE OF CHURCH OFFICIAL [Illegible]	
97. SIGNATURE OF MINISTER [Illegible]		98. SIGNATURE OF CLERGYMAN [Illegible]	
99. SIGNATURE OF CHURCH OFFICIAL [Illegible]		100. SIGNATURE OF MINISTER [Illegible]	

RECEIVED
BUREAU V. S.
APR 15 1958

4466 CERTIFICATE OF DEATH

Reg. Dist. No.

04455

1. PLACE OF DEATH o. COUNTY <u>CARROLL CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MANCHESTER</u>				c. LENGTH OF STAY IN 1b <u>about 9 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LONG VIEW NURSING HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LILLIAN MAY SALTER</u>				4. DATE OF DEATH Month Day Year <u>APRIL 15 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 8, 1874</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>PIKESVILLE, Md.</u>	
13. FATHER'S NAME <u>JAMES FRANKLIN TUCKER</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH HOOKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>MRS. P. G. Coffman, 27 RIDGE ROAD, WESTMINSTER, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>5 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 mon</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 1949</u> , to <u>April 15, 1958</u> , that I last saw the deceased alive on <u>April 15, 1958</u> , and that death occurred at <u>7P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. H. Foward</u>				ADDRESS (Street, city or town, state) <u>Manchester, Md.</u>			
PHYSICIAN'S NAME (Type) <u>W. H. Foward, M.D.</u>				DATE SIGNED <u>4/15/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/18/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DRUID RIDGE CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>PIKESVILLE, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr., Westminster, Md.</u>				ADDRESS <u>Westminster, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 18 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Rehail</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. RACE [Faint text]</p>	
<p>5. DATE OF DEATH [Faint text]</p>		<p>6. PLACE OF DEATH [Faint text]</p>	
<p>7. TIME OF DEATH [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. MANNER OF DEATH [Faint text]</p>		<p>10. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>11. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>12. SIGNATURE OF WITNESS [Faint text]</p>	

BUREAU V. S.

APR 18 1953

RECEIVED

TO HOSPITAL OR TO FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items #8 & 9-Phone call Sun. Dir. 4/30/58-mb

4467

CERTIFICATE OF DEATH

04456

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cumoll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cumoll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>WILLIAM - L - SCHAEFER</u>				4. DATE OF DEATH <u>April 27 1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/30/90</u>	
9. AGE (In years last birthday) <u>67</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Schaefer</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Davault</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-03-9857</u>			
17. INFORMANT <u>Mrs Lillian Schaefer - Manchester</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 18, 1958</u> , to <u>April 27, 1958</u> , that I last saw the deceased alive on <u>April 27, 1958</u> , and that death occurred at <u>12:00</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W H Foard</u> M.D.				ADDRESS (Street, city or town, state) <u>Manchester, Md</u>			
PHYSICIAN'S NAME (Type) <u>W. H. Foard M.D.</u>				DATE SIGNED <u>4/28/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Apr 30/58</u>		<u>Hampstead</u>		<u>Cumoll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Epton - Hampstead Md</u>				24a. REC'D BY REGISTRAR <u>APR 30 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Schaefer</u>	

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4468

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>1yr. 6mos. 26days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> <u>15x-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>			d. STREET ADDRESS <u>4021 Franklin St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lester</u> Middle <u>Lyle</u> Last <u>SCHMITTER</u>			4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>19 58</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3, 1906</u>	9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Govt. Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Economist</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Otto W. Schmitter</u>			14. MOTHER'S MAIDEN NAME <u>Amy Morgan</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-34-6535</u>		17. INFORMANT Address <u>Springfield Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Possible coronary artery spasm</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Manic Depressive Reaction, Manic type.</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James T. Marsh</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4/10/58</u>	
EXAMINER'S NAME (Type) <u>James T. Marsh, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur. - Transit</u>	22b. DATE THEREOF <u>4/11/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Richland Friends Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Richland, Iowa</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>APR 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Al. Seouch</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1
H. M. DEPT.

BUREAU V. 2

APR 14 1938

RECEIVED

Robert A. Murphy - Bethesda, Maryland
John E. Smith - Cecil, Maryland

4469

CERTIFICATE OF DEATH

Reg. Dist. No.

04458

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City 311	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		d. STREET ADDRESS 1819 Aiken St., Balto 13, Md.	
3. NAME OF DECEASED (Type or print) First Charles Middle Edward Last Seidenzahl		4. DATE OF DEATH Month 4 - Day 13 - Year 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-18-91.
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Bartender		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Seidenzahl		14. MOTHER'S MAIDEN NAME Ella Quinn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-12-5185	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491x not DUE TO Cerebral vascular hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c) C.B.S. associated with disturbances of metabolism, growth or nutrition, pre senile brain disease with psychotic reaction.			INTERVAL BETWEEN ONSET AND DEATH days days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with disturbances of metabolism, growth or nutrition, pre senile brain disease with psychotic reaction.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-6- , 19 58 , to 4-13- , 19 58 , that I last saw the deceased alive on 4-13- , 19 58 , and that death occurred at 1.10 A.M. , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Springfield State Hospital.		DATE SIGNED 4-13-58	
ACTUAL SIGNATURE Agustin del Campo		M.D. Springfield State Hospital.	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 16, 1958	22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC.		24a. REC'D BY REGISTRAR DATE	
ADDRESS Baltimore Md.		24b. REGISTRAR'S SIGNATURE DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

RECEIVED

APR 15 1958

BUREAU A. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04459

4470

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taneytown</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Taneytown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>W. Baltimore Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Wilbur</u> Middle <u>L.</u> Last <u>Shorb</u>		4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 9, 1881</u>
9. AGE (In years lost birthday) yrs. <u>77</u>		IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Shorb</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Martin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>019-01-7823</u>	
17. INFORMANT <u>John Edward Shorb, Taneytown, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Artery Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH, <u>6 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/19</u> , 19 <u>58</u> to <u>4/14</u> , 19 <u>58</u> that I last saw the deceased alive on <u>4/13</u> , 19 <u>58</u> , and that death occurred at <u>2:50</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. S. McVaugh</u> M.D.		ADDRESS (Street, city or town, state) <u>49 Frederick St. Taneytown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>R. S. McVaugh</u>		DATE SIGNED <u>4/14/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 16, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Taneytown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u>		ADDRESS <u>Taneytown, Maryland</u>	
24a. REC'D BY REGISTRAR <u>APR 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

APR 16 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04460

CERTIFICATE OF DEATH

Reg. Dist. No.

4471

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2yrs. 4mos. 13days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Annie Virginia Grace SHREVE		4. DATE OF DEATH Month Day Year April 22, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1878
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) District of Columbia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles H. Grace	
14. MOTHER'S MAIDEN NAME Sarah A. Grace		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) for Hypertensive cardiovascular disease DUE TO (c) -			INTERVAL BETWEEN ONSET AND DEATH Days Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Involuntional psychotic reaction			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 9, 1955 to April 22, 1958 , that I last saw the deceased alive on April 22, 1958 , and that death occurred at 1:25P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmund Lusthaus M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital	
DATE SIGNED 4/22/58		PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-25-58	
22c. NAME OF CEMETERY OR CREMATORY Congressional Cem.		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis Collins		24a. REC'D BY REGISTRAR APR 24 '58	
ADDRESS 3821-147th St. N.W. Wash. D.C.		24b. REGISTRAR'S SIGNATURE Redman	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1900		New York City		New York City		Heart Disease		Jan 15, 1945		10:00 AM		New York City		J. Doe, M.D.		J. Doe, M.D.	
Occupation		Marital Status		Previous Illnesses		Last Medical Examination		Date of Last Medical Examination		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar	
Teacher		Married		None		Jan 1, 1945		Jan 1, 1945		Jan 15, 1945		10:00 AM		New York City		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician	
Jan 15, 1945		10:00 AM		New York City		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.		J. Doe, M.D.	

BUREAU V. 1

APR 24 1945

RECEIVED

4420

CERTIFICATE OF DEATH

04461

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. LENGTH OF STAY IN 1b <u>93 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>14 JOHN ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ALICE</u> First <u>MARGARET</u> Middle <u>SINNOTT</u> Last				4. DATE OF DEATH <u>APRIL 7</u> Month <u>7</u> Day <u>1958</u> Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>GOULD 1864</u> 93 yrs.	
9. AGE (In years last birthday) <u>93</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS SINNOTT</u>				14. MOTHER'S MAIDEN NAME <u>REBECCA FROCK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS GEO. H. BECK</u> Address <u>HARRISBURG, PA.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONITIS</u> <u>492X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>24 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Aug. 2, 1957</u> to <u>April 7, 1958</u> , that I last saw the deceased alive on <u>April 7, 1958</u> , and that death occurred at <u>3:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Westminster Md</u> DATE SIGNED <u>4/8/58</u>							
ACTUAL SIGNATURE <u>Julius Chepko</u>				PHYSICIAN'S NAME (Type) <u>Julius Chepko</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 9/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David G. Bonhard</u> ADDRESS <u>Westminster Md.</u>				24a. REC'D BY REGISTRAR <u>APR 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938

Page Two

DECEASED

RESIDENT OF BALTIMORE, MARYLAND
JAN 21 1938

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]

CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]

DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]

DATE OF BURIAL: [illegible]
PLACE OF BURIAL: [illegible]

DATE OF INTERMENT: [illegible]
PLACE OF INTERMENT: [illegible]

DATE OF EXAMINATION: [illegible]
PLACE OF EXAMINATION: [illegible]

DATE OF SIGNATURE: [illegible]
PLACE OF SIGNATURE: [illegible]

DATE OF FILING: [illegible]
PLACE OF FILING: [illegible]

BUREAU K. E.
APR 14 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4472 CERTIFICATE OF DEATH

Reg. Dist. No.

04462

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 27 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 614 S. Kenwood Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Victoria Frances Middle Lewandowski Last SKWERES				4. DATE OF DEATH Month April Day 26 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 8, 1878	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 79		IF UNDER 24 HRS. Days 79 Hours 79 Min. 79			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory worker				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Vincent Lewandowski				14. MOTHER'S MAIDEN NAME Frances Buczkowski			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 420.0 DUE TO (c) 420.0				INTERVAL BETWEEN ONSET AND DEATH Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with cerebral arteriosclerosis.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Springfield				20g. (County) Carroll		20h. (State) Maryland	
21. I certify that I attended the deceased from March 30, 19 58 , to April 26, 19 58 , that I last saw the deceased alive on April 25, 19 58 , and that death occurred at 6:20 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 4/26/58	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr 29/58		22c. NAME OF CEMETERY OR CREMATORY Holy Cross Perfield		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W Ozazewski				ADDRESS Eastern Ave		24a. REC'D BY REGISTRAR APR 29 '58	
24b. REGISTRAR'S SIGNATURE Alfred							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 29 1958

BUREAU V. 3

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BATHING

4473

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Springfield, Hosp., Sykesville		c. LENGTH OF STAY IN 1b 10 mos. 16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth Pauline Engle SMITH		4. DATE OF DEATH Month Day Year April 24, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 10, 1895
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Engle		14. MOTHER'S MAIDEN NAME Caroline Cline	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic heart disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with other diseases of unknown or uncertain cause, with psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 8, 1957 , to April 24, 1958 , that I last saw the deceased alive on April 24, 1958 , and that death occurred at 12:33 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustin del Campo M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4/24/58	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/24 / 1958	22c. NAME OF CEMETERY OR CREMATORY Pleasant Hill	22d. LOCATION (City, town, or county) (State) Rural Frederick MD
23. FUNERAL DIRECTOR'S SIGNATURE G. C. Barton		ADDRESS Walkersville MD	
24a. REC'D BY REGISTRAR APR 28 '58		24b. REGISTRAR'S SIGNATURE W. L. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 28 1958

RECEIVED

4474 CERTIFICATE OF DEATH

04464

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville	c. LENGTH OF STAY IN 1b 3 mos. 7 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 4903 Greenhill Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Stella Middle Stephanie Last Zadaikes STOKES		4. DATE OF DEATH Month April Day 14 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 20, 1894
9. AGE (In years lost birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Lithuania	12. CITIZEN OF WHAT COUNTRY? Lithuania
13. FATHER'S NAME Anthony Zadaikes		14. MOTHER'S MAIDEN NAME Ursula Yogens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. -	17. INFORMANT Address Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) C.B.S. associated with arteriosclerosis, with psychotic reaction.			INTERVAL BETWEEN ONSET AND DEATH Minutes
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 7, 19 58 to April 14, 19 58 , that I last saw the deceased alive on April 14, 19 58 , and that death occurred at 11:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmund Lusthaus M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4/14/58	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/17/58	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		ADDRESS 5305 Harford Road #14	24a. REC'D BY REGISTRAR APR 21 58 24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Occupation		Education		Medical History		Post-mortem Examination	
Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Witness	
Date of Report		Time of Report		Place of Report		Signature of Reporter	

BUREAU Y. 2

APR 21 1958

RECEIVED

4475

CERTIFICATE OF DEATH

04465

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 20yrs. 7mos. 15days Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS Unknown - had been at Balto. City Hospitals previously.	
3. NAME OF DECEASED (Type or print) First Josephine Middle THORNBERG Last THORNBERG		4. DATE OF DEATH Month April Day 22, Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY unk	11. BIRTHPLACE (State or foreign country) Ireland
13. FATHER'S NAME Michael Gaule		14. MOTHER'S MAIDEN NAME Kate Walsh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		17. INFORMANT Springfield Hospital Records	
16. SOCIAL SECURITY NO. -		12. CITIZEN OF WHAT COUNTRY? Unknown	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO 430.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH Years Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia, paranoid type.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 20, 1954 to April 22, 1958 , that I last saw the deceased alive on April 21, 1958 , and that death occurred at 4:20A M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmund Lusthaus		ADDRESS (Street, city or town, state) Springfield Hospital	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		DATE SIGNED 4/22/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-25-58	22c. NAME OF CEMETERY OR CREMATORY New Cathedral	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight		24a. REC'D BY REGISTRAR APR 23 1958	
ADDRESS Sykesville, Md.		24b. REGISTRAR'S SIGNATURE Al. Leach	

CERTIFICATE OF DEATH

MAINTAINED STATE DEPARTMENT OF HEALTH - BOSTON, 10

RECEIVED
BOSTON
APR 28 1933

BUREAU V. E.

APR 28 1933

RECEIVED

4476 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>				c. LENGTH OF STAY IN 1b <u>4 Month</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>Virginia</u> Last <u>Wantz</u>				4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 11, 1890</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Tobias A. Martin</u>			
14. MOTHER'S MAIDEN NAME <u>Ida Catherine Ohler</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>no</u>			
16. SOCIAL SECURITY NO. <u>unknown</u>				17. INFORMANT <u>Kermit Wieshaar, Westminster, Md. R.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 1, 1950</u> to <u>Apr. 13, 1958</u> that I lost saw the deceased alive on <u>April 12, 1958</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. Reese Wilkens</u> M.D.				ADDRESS (Street, city or town, state) <u>15 Kemper Ave Westminister, Md.</u>			
DATE SIGNED <u>4/14/58</u>				22. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>April 16, 1958</u>				22c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN CEMETERY Pleasant Valley, Maryland</u>			
22d. LOCATION (City, town, or county) (State) <u>Taneytown Pleasant Valley, Maryland</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u>			
ADDRESS <u>Taneytown, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>APR 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH - BATHING
CERTIFICATE OF DEATH

Form No. 10

1. Name of Deceased

2. Sex

3. Date of Birth

4. Place of Birth

5. Date of Death

6. Place of Death

7. Cause of Death

8. Manner of Death

9. Signature of Physician

10. Signature of Registrar

11. Signature of Coroner

12. Signature of Medical Examiner

13. Signature of Health Officer

14. Signature of County Clerk

15. Signature of State Registrar

16. Signature of State Health Officer

17. Signature of State Coroner

18. Signature of State Medical Examiner

19. Signature of State Health Officer

20. Signature of State Coroner

21. Signature of State Medical Examiner

22. Signature of State Health Officer

23. Signature of State Coroner

24. Signature of State Medical Examiner

25. Signature of State Health Officer

26. Signature of State Coroner

27. Signature of State Medical Examiner

28. Signature of State Health Officer

29. Signature of State Coroner

30. Signature of State Medical Examiner

31. Signature of State Health Officer

32. Signature of State Coroner

33. Signature of State Medical Examiner

34. Signature of State Health Officer

35. Signature of State Coroner

36. Signature of State Medical Examiner

37. Signature of State Health Officer

38. Signature of State Coroner

39. Signature of State Medical Examiner

40. Signature of State Health Officer

41. Signature of State Coroner

42. Signature of State Medical Examiner

43. Signature of State Health Officer

44. Signature of State Coroner

45. Signature of State Medical Examiner

46. Signature of State Health Officer

47. Signature of State Coroner

48. Signature of State Medical Examiner

BUREAU V. S.

APR 16 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4477 CERTIFICATE OF DEATH

04467

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery 172	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 15X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		d. STREET ADDRESS 5910 Walton Road	
3. NAME OF DECEASED (Type or print) First Edwin Middle Charles Last Wendler		4. DATE OF DEATH Month 4 - Day 27 - Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 -30 -1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY —	9. AGE (In years last birthday) yrs. 61
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Wendler		14. MOTHER'S MAIDEN NAME Christina Hoffnagle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. MD/C 1917-18 578-07-3936	
17. INFORMANT Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Old myocardial infarction (c) Coronary arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH Days Years Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with cerebral arteriosclerosis.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-11-1958 to 4-27-1958 , that I last saw the deceased alive on 4-27-1958 , and that death occurred at 6.00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustin del Campo		ADDRESS (Street, city or town, state) Springfield State Hospital.	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		DATE SIGNED 4-27-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/30/58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		24a. REG'D BY REGISTRAR Bethesda, Maryland	
24b. REGISTRAR'S SIGNATURE Alfred		DATE APR 30 1958	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		35		10-15-1885	
Place of Birth		Cause of Death		Date of Death		Time of Death	
Baltimore, Md.		Heart Disease		10-20-1920		10:00 AM	
Occupation		Signature of Physician		Signature of Registrar		Signature of Informant	
Teacher		J. H. Smith		A. B. Jones		C. D. Brown	
Residence		Manner of Death		Place of Death		Date of Burial	
123 Main St.		Natural		St. Mary's Church		10-25-1920	

BUREAU N. 1

APR 30 1958

RECEIVED

4478 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>				c. LENGTH OF STAY IN 1b <u>4yrs. 6mos. 3days</u> Union Bridge X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>---</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fern</u> Middle <u>Myers</u> Last <u>WRIGHT</u>				4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 27, 1897</u>		9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Union Bridge, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>William Wright</u>				14. MOTHER'S MAIDEN NAME <u>Cora Myers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>220-32-2836</u>		17. INFORMANT Address <u>Sykesville, Md.</u> <u>Records of Springfield State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>---</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>more than 5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mental deficiency, familial or hereditary, severe, with psychotic reaction, unclassified.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>---</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>	
				20f. (City or town) (County) (State) <u>---</u>			
21. I certify that I attended the deceased from <u>August 1</u> , 19 <u>55</u> , to <u>April 29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 28</u> , 19 <u>58</u> , and that death occurred at <u>1:40 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter Knopp</u>				ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>		DATE SIGNED <u>4/29/58</u>	
PHYSICIAN'S NAME (Type) <u>Walter Knopp, M. D.</u>				<u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-2-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Uniontown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.M. Walz</u> ADDRESS <u>Winfield, Md.</u>				24a. REC'D BY REGISTRAR <u>---</u> DATE <u>MAY 1 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Overman</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

44-78 - CERTIFICATE OF DEATH

REG. DIV. 10

NAME OF DECEASED JAMES H. HARRIS		DATE OF DEATH JAN 23 1951	
PLACE OF DEATH HOME		CITY BALTIMORE	
COUNTY BALTIMORE		STATE MARYLAND	
AGE 65		SEX M	
MARRIAGE MARRIED		OCCUPATION RETIRED	
EDUCATION HIGH SCHOOL		RELIGION METHODIST	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. H. HARRIS		SIGNATURE OF REGISTRAR J. H. HARRIS	
DATE OF SIGNATURE JAN 23 1951		DATE OF SIGNATURE JAN 23 1951	
PLACE OF SIGNATURE HOME		PLACE OF SIGNATURE OFFICE	
CITY BALTIMORE		CITY BALTIMORE	
COUNTY BALTIMORE		COUNTY BALTIMORE	
STATE MARYLAND		STATE MARYLAND	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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U.S. DEPARTMENT OF HEALTH—BALTIMORE, 18											
Item 14, Film G-228 4/21/58.cas											
4479 CERTIFICATE OF DEATH											
Reg. Dist. No. 04469											
1. PLACE OF DEATH o. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN 1b 3yrs. 8mos. 11days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital					d. STREET ADDRESS 4523 Manorview Rd., Balto. 29			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle Henry Last WUNDER					4. DATE OF DEATH Month April Day 18 , Year 1958						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 31 October, 1878		9. AGE (In years last birthday) 79 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Unknown John Wunder					14. MOTHER'S MAIDEN NAME Unknown Mary (n.k.a.) Rothlingshofer						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Springfield Hospital Records							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Coronary arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchopneumonia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with dist. of metabolism, growth or nutrition, with senile brain disease with psychotic reaction.										INTERVAL BETWEEN ONSET AND DEATH Years Years Days	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from March 7, 1955 , to April 18, 1958 , that I last saw the deceased alive on April 17, 1958 , and that death occurred at 6:10A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 4/18/58											
ACTUAL SIGNATURE Agustin del Campo M.D.					PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. Sykesville, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/21/58		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.			22d. LOCATION (City, town, or county) Balto., Md.				
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mr. J. Vickers & Sons - Balto 17th					24a. REC'D BY REGISTRAR DATE APR 21 '58		24b. REGISTRAR'S SIGNATURE Overman				

CERTIFICATE OF DEATH

DECEASED NAME JOHN J. BROWN		SEX MALE		AGE 45	
PLACE OF BIRTH BOSTON, MASS.		DATE OF BIRTH JAN 15 1900		TIME OF DEATH 10:30 AM	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
PLACE OF DEATH HOME		DATE OF DEATH APR 10 1958		TIME OF DEATH 10:30 AM	
SIGNATURE OF PHYSICIAN J. J. BROWN		SIGNATURE OF REGISTRAR J. J. BROWN		SIGNATURE OF WITNESS J. J. BROWN	

BUREAU V. 3

APR 22 1958

RECEIVED

4480 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>				c. LENGTH OF STAY IN 1b <u>21 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTMINSTER, Md. RD #3</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>ELSWORTH</u> Last <u>ZEPP</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov-10, 1875</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>self-employed Carroll Co. Md.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Andrew J. Zepp</u>				14. MOTHER'S MAIDEN NAME <u>Mollie Metzler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>212-38-1392</u>		17. INFORMANT <u>Miss Ruth Zepp, Westminister, Md RD #3</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> 430.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>SEVERAL YEARS</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 MONTHS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>OCTOBER</u> , 19 <u>57</u> , to <u>APRIL</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>APRIL 28</u> , 19 <u>58</u> , and that death occurred at <u>6:05 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>19 N. Church St</u> DATE SIGNED <u>4/30/58</u> ACTUAL SIGNATURE <u>Daniel J Welliver</u> M.D. <u>Westminister Maryland</u> PHYSICIAN'S NAME (Type) <u>DANIEL J. WELLIVER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 3, 58</u>		<u>Seeters Cemetery</u>		<u>Rural Westminister, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr., Westminister, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>MAY 1 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of Deceased</p> <p>2. Sex</p> <p>3. Age</p> <p>4. Date of Birth</p> <p>5. Date of Death</p> <p>6. Place of Birth</p> <p>7. Usual Residence</p> <p>8. Cause of Death</p> <p>9. Duration of Illness</p> <p>10. Place of Death</p> <p>11. Signature of Physician</p> <p>12. Signature of Registrar</p> <p>13. Date of Registration</p> <p>14. Name of Registrar</p> <p>15. Name of District</p> <p>16. Name of County</p> <p>17. Name of State</p>		<p>18. Name of Hospital</p> <p>19. Name of Physician</p> <p>20. Name of Nurse</p> <p>21. Name of Assistant</p> <p>22. Name of Attendant</p> <p>23. Name of Burial Place</p> <p>24. Name of Burial</p> <p>25. Name of Burial</p> <p>26. Name of Burial</p> <p>27. Name of Burial</p> <p>28. Name of Burial</p> <p>29. Name of Burial</p> <p>30. Name of Burial</p> <p>31. Name of Burial</p> <p>32. Name of Burial</p> <p>33. Name of Burial</p> <p>34. Name of Burial</p> <p>35. Name of Burial</p> <p>36. Name of Burial</p> <p>37. Name of Burial</p> <p>38. Name of Burial</p> <p>39. Name of Burial</p> <p>40. Name of Burial</p> <p>41. Name of Burial</p> <p>42. Name of Burial</p> <p>43. Name of Burial</p> <p>44. Name of Burial</p> <p>45. Name of Burial</p> <p>46. Name of Burial</p> <p>47. Name of Burial</p> <p>48. Name of Burial</p> <p>49. Name of Burial</p> <p>50. Name of Burial</p> <p>51. Name of Burial</p> <p>52. Name of Burial</p> <p>53. Name of Burial</p> <p>54. Name of Burial</p> <p>55. Name of Burial</p> <p>56. Name of Burial</p> <p>57. Name of Burial</p> <p>58. Name of Burial</p> <p>59. Name of Burial</p> <p>60. Name of Burial</p> <p>61. Name of Burial</p> <p>62. Name of Burial</p> <p>63. Name of Burial</p> <p>64. Name of Burial</p> <p>65. Name of Burial</p> <p>66. Name of Burial</p> <p>67. Name of Burial</p> <p>68. Name of Burial</p> <p>69. Name of Burial</p> <p>70. Name of Burial</p> <p>71. Name of Burial</p> <p>72. Name of Burial</p> <p>73. Name of Burial</p> <p>74. Name of Burial</p> <p>75. Name of Burial</p> <p>76. Name of Burial</p> <p>77. Name of Burial</p> <p>78. Name of Burial</p> <p>79. Name of Burial</p> <p>80. Name of Burial</p> <p>81. Name of Burial</p> <p>82. Name of Burial</p> <p>83. Name of Burial</p> <p>84. Name of Burial</p> <p>85. Name of Burial</p> <p>86. Name of Burial</p> <p>87. Name of Burial</p> <p>88. Name of Burial</p> <p>89. Name of Burial</p> <p>90. Name of Burial</p> <p>91. Name of Burial</p> <p>92. Name of Burial</p> <p>93. Name of Burial</p> <p>94. Name of Burial</p> <p>95. Name of Burial</p> <p>96. Name of Burial</p> <p>97. Name of Burial</p> <p>98. Name of Burial</p> <p>99. Name of Burial</p> <p>100. Name of Burial</p>
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1. Name of Deceased

2. Sex

3. Age

4. Date of Birth

5. Date of Death

6. Place of Birth

7. Usual Residence

8. Cause of Death

9. Duration of Illness

10. Place of Death

11. Signature of Physician

12. Signature of Registrar

13. Date of Registration

14. Name of Registrar

15. Name of District

16. Name of County

17. Name of State

18. Name of Hospital

19. Name of Physician

20. Name of Nurse

21. Name of Assistant

22. Name of Attendant

23. Name of Burial Place

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